# REGISTRATION OF RADIATION MACHINE FACILITIES



**FACILITY**

NAME: _____

ADDRESS:_____

_____

TELEPHONE: ( ) _____

**RADIATION SAFETY PERSON (RSO)**

NAME: _____

ADDRESS:_____

_____

TELEPHONE: ( ) _____

**RADIATION MACHINE**

MANUFACTURER: _____

_____

MODEL NUMBER: _____

CONSOLE SERIAL: _____

TUBE SERIAL: _____

RATING - MAX. kVp: _____

MAX. mA: _____

SUPPLIER: _____

INSTALLER: _____

SERVICE AGENT: _____

[1] STATIONARY

[2] PORTABLE

[3] MOBILE

GEOG. LOCATION: _____

**ADMINISTRATOR/MACHINE OWNER**

NAME: _____

ADDRESS:_____

_____

TELEPHONE: ( ) _____

SIGNATURE: _____

Date Form Completed:_____

**TYPE OF PRACTICE**

| | | | |
|---|---|---|---|
| [1] | Medical | [7] | Schools |
| [2] | Dental | [8] | Hospital |
| [3] | Podiatric | [9] | Mammographic |
| [4] | Chiropractic | [10] | Colleges |
| [5] | Industrial | [11] | OTHER |
| [6] | Veterinary | [12] | State owned and operated |

**FACILITY SUPERVISOR**

NAME: _____

SIGNATURE: _____

**RADIATION MACHINE**

**TYPE OF MACHINE:**

[1] Dental

[2] Radiographic

[3] Fluoroscopic

[4] Intensifier

[5] Computerized Tomography

[6] Cephalometric

[7] Panographic

[8] Combination Fluoro - Radiographic

[9] Therapy

[10] Industrial

[11] OTHER

[12] Mammographic

[13] Bone Densitometry

ROOM # _____

**INSPECTION**

DATE OF LAST INSPECTION: _____

INSPECTED BY WHOM: _____

_____

[ ] NEVER INSPECTED

***OFFICE USE ONLY:***

**FACILITY ID #: _____**

**RECEIPT #: _____**

**AMOUNT: _____**

**REGISTRATION #: _____**

**EXPIRATION DATE: _____**

**TOTAL # OF TUBES: _____**